Primary Care Physician Responsibilities

The Primary Care Physician (PCP) is responsible for the MIHS member's total care and coordinates all medical care provided to the member. Members select or are assigned a PCP when they enroll with MIHS. Members may change PCPs by contacting Member Services. There is no limit set for PCP changes. The PCP ensures that the member receives the highest level of care in the most appropriate setting. The PCP's role as a gatekeeper requires that he/she arrange tests, specialty referrals, behavioral health, therapies, and home/community-based services for the member. The PCP must maintain an accurate record of all services received/required and the outcomes. MIHS expects the PCP to retain control, responsibility, and accountability for the care and services delivered to the member when referred to other providers. Referrals are usually temporary and do not absolve the PCP of management responsibilities for the overall health of the member.

The PCP is responsible for actively cooperating with MIHS to meet the standard levels of care as prescribed by regulatory agencies, such as AHCCCS and HFCA. Areas MIHS will measure for compliance include childhood/adult immunizations, well-child visits, pap smears, mammograms, dental preventive care/treatment, low birth weights, Beta Blocker treatment after a heart attack, eye exams for diabetics, antidepressant medication management, cholesterol management after acute cardiovascular events, and any other mandated QISMC projects.

Physician profile data is created to measure physicians against their peers for over and under utilization. Data, based on the PCP's assigned patient panel, may include the measures listed in the previous paragraph plus pharmacy costs, office visits, admission bed days, lab tests, x-rays, and referral costs per 1000 members. Profiling data will remain a permanent part of the physician's quality file and MIHS will utilize the information for recredentialing purposes, along with quality of care or customer service concerns involving the provider.

MIHS defines the PCP's role to include the following professional attributes and expectations:

- Initial assessment within ninety (90) days of the member's effective date of enrollment

- Maintaining a health record for each MIHS member assigned, taking into account professional standards, as well as appropriate and confidential exchange of information among provider network components. MIHS-HP providers must safeguard the privacy of information that identifies a particular member. Information may be released to authorized persons only. In the case of a new MSO (Managed Services Organization) or PCP selection, medical records must be forwarded to the new PCP or MSO as soon as possible. Original medical records must only be released in accordance with Federal or State laws, court orders or subpoenas. Records must be maintained in an accurate and timely manner. Information regarding advance directives must be kept in a prominent place in the member's file. Clear and concise communication with the member in language that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must all be documented in the member's file. ***The practice must have a process in place to arrange for interpretive services if necessary.*** Members and Providers must have timely access to records. Medical records must be maintained for at least six (6) years.

- Communicating to the member regarding specific health care needs that require follow-up and training. MIHS-HP expects that Providers will communicate with its members in a timely fashion regarding their medical care. Clear and concise communication with the

member in a language and manner that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must be clearly communicated. This communication must be documented in the member's file.

- MIHS-HP expects that Providers will communicate with each other regarding the needs of it's members in a timely fashion. This includes but is not limited to diagnostic results, treatment plans, social and economic factors that may or may not impact the treating physician's ability to care for his/her patient. Test results and other outcomes should be provided to the referring physician as well as the member's PCP as soon as possible. This communication should become a part of the patient's medical record.

- Development of a treatment plan in coordination with appropriate medical personnel, clinic case managers, MIHS case management staff and external network providers for members identified as having a complex or serious medical condition. Treatment plans for high-risk members are dated, reviewed, and updated as often as needed, but not less than every 3 to 6 months, or as the member's condition warrants. Examples of complex conditions include transplants, brain tumor, closed head injuries, myocardial infarction, asthma, ventilator dependent members; leukemia, trauma (i.e., burn, amputations, spinal cord injuries), AIDS, diabetes, and sickle cell disease

- Maintain continuity of care by reducing duplication of diagnostic procedures by including all medical records for services provided to the member and forwarding these to the specialist

- Referring MIHS members to participating specialty providers as needed to maintain the member's well being

- The PCP must be available twenty-four (24) hours a day, seven days a week or arrange coverage with a MIHS participating physician to provide member access during his/her absence

- Maintain an office that is clean, safe, accessible, and supportive of member privacy and confidentiality

- PCP agrees to only bill members for copays, deductibles, and/or coinsurance as specified by the member's benefit coverage

- The PCP must have a process in place to set up files for patients that have not presented for treatment. This process is to ensure Health Plan information regarding the patient will be available when the patient presents. The PCP will receive confidential behavioral health information from the Value Options Provider regarding assigned patients. As required by AHCCCS the PCP will establish a file (or medical

- record) when information is received from the RBHA, even if the PCP has not yet seen the assigned member).

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Eligibility Verification

It is important that all MIHS providers verify a member's enrollment with MIHS. Presentation of a MIHS and/or AHCCCS ID card is not sufficient verification of enrollment.

MIHS Family Health Centers, the Comprehensive Health Center, and Maricopa Medical Center may use the Member Maintenance System to verify a member's status with MIHS.

All other providers can verify a member's participation as follows:

- Contact MIHS Provider Services department at 602/344-8957, Monday – Friday from 8:00a.m. to 5:00p.m. The member's ID number will be necessary to verify eligibility;
- After regular business hours, on weekends or holidays, call the Authorization Unit at 602/344-8111.

All MIHS providers MUST verify membership status. Failure to do so may result in reduced or denied payments.

If an MIHS member seeks services from a PCP other than the one he/she has selected, the PCP staff must advise the member to return to his/her selected PCP, **UNLESS** it is an emergent or urgent care situation. Members may contact Member Services at 602 344 8760 to change their PCP. There is no limit to the number of PCP changes.

PCPs are required to provide Early and Periodic Screen Diagnosis and Treatment (EPSDT) to eligible members. EPSDT is a federal program designed to ensure all eligible children receive needed medical services, including immunizations for childhood diseases.

Immunizations are to be documented in the member's record, reported to the health plan and the State of Arizona. Online reporting to the State is under development.

Copayments

PCP may collect appropriate copayments directly from the MIHS member. Providers must notify a member of copayments **before** performing the care/service. Providers are free to make payment arrangements with the member as they choose, provided such arrangements follow written policies, procedures, and accepted business practices. A provider may not charge a member an additional fee for delayed or billed copayments. Providers must notify MIHS Member Services if a member fails to make timely copayments. MIHS will send notification to the member regarding their obligations and rights regarding overdue copayments.

Provider Standards

Accessibility of Office/Appointment Standards

MIHS has established standard time frames for scheduling office appointments and waiting periods in a physician's office. The standards are as follows:

Routine Appointment	21 days
Urgent Care	24 to 48 hours
Emergent Care	Same day
Prenatal:	
First Trimester	14 days
Second Trimester	7 days
Third Trimester	3 days
High Risk Pregnancy	Same day
Wait time in office	30 minutes or less
Phone Availability:	
Number of rings until answer	Less than 5 rings
Time on hold after answer	Less than 5 minutes
After Hours Service	Answer Service, or Recording w/pager number for physician, or Answering machine that pages physician. (Directing Member to Emergency Room will be viewed as non-compliant)

Important – If a physician or the covering physician is unable to schedule an urgent care visit for a MIHS member the same day, please refer the member to MIHS Member Services Department at 602/344-8760.

Physician Availability

MIHS PCPs must ensure that coverage is provided twenty-four (24) hours a day, seven days a week. The covering physician must be available to review and approve the hospitalization or referral of members to specialists or facilities.

Sub-Contractors

MIHS contracted providers may subcontract with other providers for certain health care services, including medical specialists, radiology, laboratory, supplies and equipment, among others. Providers who subcontract are required to perform the following:

- Contract with licensed, certified, and/or registered providers when applicable. Providers must credential their subcontractors and maintain current files on each provider that includes the credentialing documents
- Submit all sub-contractor agreements to MIHS for approval
- Monitor the quality of care and services provided to MIHS members by subcontractors
- Obtain, and report to MIHS, encounter data for subcontractors

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- Assure timely payment, based on written policies and procedures, to their subcontractors
- Sub-contractors must agree to uphold the same standards and requirements as MIHS is held to by its regulatory agencies

MIHS must ensure that all providers who serve its members are Medicare/AHCCCS certified (when applicable) and abide by HCFA/AHCCCS regulations. MIHS' contracted providers must apply this rule to their subcontractors who serve MIHS members.

MIHS expects providers to pay subcontractor claims or billings within twenty-seven (27) days of the date billed. If the provider has not made payment, MIHS has the option of paying the claim, then deducting the amount from any payments due to the delinquent provider.